Editorial

Lack of Insight in Psychiatric Illness: A Critical Appraisal

SETTING THE STAGE FOR DISCUSSION: EVOLUTION OF THE CONCEPT AND IMPORTANCE

The concept of insight in psychiatric discourse has evolved through various stages. Psychiatrists or 'the doctors of the soul' have sincetimes immemorial been curious about the attitudes and perspectives of persons with mental illness towards their disturbed minds/selves. Though discussed by alienists in the mid-19th century and few psychopathologists in the early 20th century, the concept has seen a great progress in its understanding over the last 25 years. The concept has progressed through the following stages:

- Insight into illness as present or absent dichotomy (e.g., IPSS)[1,2]
- One dimensional grading of Insight[3] from Complete Denial (grade 1) to True Emotional Insight (grade 6). This model incorporated understanding of causation as due to internal or external factors.
- Multidimensional models[4,5], which are referred to as 'biomedical models' by their anthropological critics.
- The socio-cultural modifications of multidimensional models[6] and the concept of Narrative Insight.[7]

The reason so much of global discussion and research is going into this one topic is its clinical, administrative and legal importance. The clinical practice of covert (or surreptitious) medication and involuntary admission into a psychiatric health facility are very difficult things to come to terms with. Not only is the practice of involuntary treatment/admission a clinical concern, it is also an administrative concern for the psychiatric health facility. Issues like use of physical restraints and involuntary treatment/admission usually go against the liberal understanding of Human Rights. Apart from the clinical and administrative concerns, even the legal concerns of criminal responsibility, capacity for informed consent and validity of a will depend upon the understanding of the concept of insight (or the related issues of personal, social and moral judgment) of the person suffering with a mental illness.

So, the establishment of the lack of insight in a person suffering from mental illness is of utmost importance for the clinical, administrative and legal reasons.

DIFFICULTY IN THE CLARITY AND UTILITY OF THE CONCEPT OF INSIGHT

The concept of lack of insight, because of its importance needs clear conceptualization. Clarity in its conceptualization and its utility remain as major problems for four reasons:

- Lack of insight means different things in different psychiatric conditions. For example lack of insight means various things in the following conditions: psychosis, depression, obsessive-compulsive disorder, personality disorder, paraphiliac disorders, substance addictions etc.
- Criteria or definitions used even for a particular condition like Schizophrenia are different when used by different researchers. Some of which seem very utopian and almost unachievable when applied in routine clinical practice (example: Karl Jaspers' need for a 'completely objective attitude'[8] or Amador & David's need for meeting the five criteria in a fullest sense).[5] Some like Aubrey Lewis' definition[9] are broad and vague.
- Different schools of psychiatry ascribe different etiological reasons or reformulations of the concept of lack of insight. The understanding of causation and treatment vary among various schools of psychiatry whereby if one school considers that

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the person who takes western medical treatment is the one with optimal insight, the other school thinks that use of non-medical treatment is also a correct attitude towards treatment. Cultural psychiatrists[7,10,11] discuss the lack of insight as only a coping strategy (or as just a way of explaining the disorder to oneself) without taking neurobiology of disorder into consideration.

- The ontological nature of the Human Insight into subjective experiences or lack of it is very complex. The study of Human Insight covers various fields like Neuroscience, Psychiatry, Psychology, Socio-cultural/ Anthropological studies, Linguistics and Philosophy.[12] This aspect hinders the clinical utility of a broad definition of Insight which covers all the above mentioned aspects. Even within clinical psychiatry, the nature of Insight is varied in different conditions e.g., it is thought to be a state phenomenon in Bipolar/Episodic psychosis and a trait phenomenon in Schizophrenia.

BILL FULFORD & LINGUISTIC ANALYSIS: ATTEMPTS AT CLARIFYING THE CONCEPT

KWM (Bill) Fulford applies the philosophical method of linguistic analysis which was initially proposed by Ludwig Wittgenstein and later elaborated by the Oxford philosopher of language J L Austin, to the task of clarifying the concept of Insight in psychiatric illness. He argues that, for a large class of cases, though not for all, the meaning of a word usually is best found in its usage. When applied to the concept of insight, it means that to get a clearer view we have to look carefully at the way psychiatrists use the term.

Of all the available tools to clarify the meaning of the concept, linguistic analysis is useful because of the kind of conceptual problems in psychiatry which don't just need elaborate theorizing but require practical utilityand also because it uses empirical methodology as in clinical psychiatry.[13] Fulford by using various case studies discusses three logically significant features which psychiatrists use when they deal with the concept of lack of insight.[14] They are:

- The loss of insight is typically associated with the presence of hallucinations, delusions, thought alienation and other passivity phenomena
- Delusions are the central symptoms of mental illness with respect to its ethical and medicolegal significance.
- Apart from being true or false factually, delusions have an evaluative or value judgment dimension to them in that they can be positive (as in mania) or negative (as in depression).

As we have observed earlier the medicolegal significance gives the concept its importance. In illnesses like dementia because there is demonstrable cognitive damage and resultant impairment, the law perceives any acts as being associated with minimal or no responsibility at all;and now (especially over last 5 years) as we shall discuss later in this issue,[15] current research proposes similar distinct and particular neuro-cognitive changes and related impairment in the psychotic illness.

In Fulford's 'Fact + Value' model of psychiatry, a body part or an organ has its purpose or function but a 'person' has reasons for action. If delusions and lack of insight require an excuse in law, then it means that any (culpable) action by a person with the lack of insight should have a failure of reasons for action i.e. as an accident or a mistake and therefore he cannot be held morally responsible in the same sense as of a healthy person. According to him, evaluative dimensions with the positive or negative connotations arise from the failure of reasons for action. This opens up the space to discuss the various personal aspects of narrative insight and lack of insight as a coping strategy.

IN THIS ISSUE

This issue of Indian Journal of Psychological Medicine has four articles on the topic of the concept of Insight. Article by Mythri and Sanjay,[15] discusses the development of the concept and the recent neurobiological research on it. The research discussed in this article represents the fruit of past 5 years of labor in this area. Some findings are replicated and others need further study but on the whole the line of research which investigates the Cortical Midline Structures (CMS) is very promising.

Article by Jacob,[16] presents a socio-cultural perspective and attempts to reframethe concept of insight as an explanatory model. We know that the insight in psychosis plays a part in coping with symptoms at the onset of the illness and with residual disabling symptoms but equating insight with explanatory model confuses the terms used. Insight is a broader term used to refer to patient's judgment and attitudes towards his illness at its various stages. We consider that only few aspects of the multidimensional construct of insight can be thought of as relating to the explanatory models. He also reviews recent studies related to insight, explanatory models and outcome of psychosis and through them argues that insight cannot be seen as an independent predictor of the outcome of psychosis but should be seen as part of progression of illness.

Original research article by Ramachandran *et al.*[17],

adds to the available research which shows significant difference in insight during remission between the patients with schizophrenia and patients with bipolar disorder. Around 40% in the schizophrenia group compared to none in the bipolar disorder group were unaware of their mental illness. They also showed correlation between insight and compliance with treatment. Another study by Mehdizadeh and Rezaei,[18] tried to test ways of interviewing and association between clinical and cognitive insight.

CURRENT UNDERSTANDING AND THE WAY FORWARD

Keeping in mind the various complexities of the concept and its clinical use, we have to understand it complexly. Current neurobiological, clinical and anthropological research paints a mosaic picture of the concept of lack of insight. As suggested by the multidimensional models, it encompasses various dimensions of awareness, attribution and treatment use. Some dimensions relate to how the individual uses his metacognitive abilities to understand and reframe the illness experience and thereby strategically use beliefs and judgments derived from the immediate social and cultural contexts to cope with the illness experience. And these metacognitive abilities might work through the proposed brain areas like Cortical Midline Structures.

The ethical and medicolegal aspects of the concept derive their importance from the psychotic processes like delusion. This has a very crucial practice implication which is derived from the clarification by the linguistic analysis that the concept of lack of insight when used in discussion only makes sense when the discourse is about a psychotic illness and not when the non-psychotic illnesses like substance addictions, personality disorders, anxiety disorders are considered.

The way forward is one of integration of various phenomenological, neurobiological and socio-cultural findings. The term 'lack of insight' hereafter may be used in a nuanced way and restricted to the discourse on the psychotic illness.

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REFERENCES

1. Sartorius N, Shapiro R, Jablensky A. The international pilot study of schizophrenia. Schizophr Bull. 1974;1:21–34.
2. WHO. Report of The International Pilot Study of Schizophrenia [Internet]. World Health Organization; 1973 [cited 2016 Jan 3]. Available from: http://apps.who.int/iris/bitstream/10665/39405/1/WHO_OFFSET_2_(chp1-chp8).pdf
3. Sadock BJ, Sadock VA. Psychiatric History and Mental Status Examination. In: Kaplan & Sadock's Synopsis of Psychiatry. 10th Edition. Philadelphia, PA, USA: Lippincott Williams & Wilkins; 2007. p. 237.
4. David AS. Insight and psychosis. Br J Psychiatry. 1990;156:798–808.
5. Amador XF, David AS, editors. Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders. 2 edition. Oxford ; New York: OUP Oxford; 2004. p. 416.
6. Saravanan B, David A, Bhugra D, Prince M, Jacob KS. Insight in people with psychosis: the influence of culture. Int Rev Psychiatry Abingdon Engl. 2005;17:83–7.
7. Tranulis CS, Freudenreich O, Park L. Narrative insight: rethinking insight in psychosis. Int J Cult Ment Health. 2009;2:16–28.
8. Jaspers K. The patient's attitude to his illness. In: General Psychopathology. Johns Hopkins Paperbacks edition. London: The Johns Hopkins University Press; 1913. p. 414–27.
9. Lewis A. The Psychopathology of Insight. Br J Med Psychol. 1934;14(4):332–48.
10. Roe D, Hasson-Ohayon I, Kravetz S, Yanos PT, Lysaker PH. Call It a Monster for Lack of Anything Else. J Nerv Ment Dis. 2008;196:859–65.
11. Jacob KS. Insight in psychosis: An independent predictor of outcome or an explanatory model of illness? Asian J Psychiatry. 2014;11:65–71.
12. Kircher T, David AS. Self-consciouness: an intergrative approach from philosophy, psychopathology and the neurosciences. In: The Self in Neuroscience and Psychiatry. Cambridge, United Kingdom: Cambridge University Press; 2003. p. 445–73.
13. Fulford KWM. Oxford Textbook of Philosophy and Psychiatry. Oxford University Press; 2006.
14. Fulford KWM. Completing Kraeplin's Psyhcopathology: Insight, Delusion and the Phenomenology of Illness. In: Amador XF, David AS, editors. Insight and Psychosis. New York, USA: Oxford University Press; 1998. p. 47–65.
15. Mythri SV, Sanjay Y. Recent neurobiological insights into the concept of insight in psychosis. Indian J Psychol Med. 2016;38:189–93.
16. Jacob KS. Insight in psychosis: An indicator of severity of psychosis, an explanatory model of illness, and a coping strategy. Indian J Psychol Med. 2016;38:194–201.
17. Ramachandran AS, Ramanathan R, Praharaj SK, Kanradi H, Sharma PSVN. A cross-sectional, comparative study of insight in schizophrenia and bipolar patients in remission. Indian J Psychol Med. 2016;38:207–12.
18. Mehdizadeh M, Rezaei O. Third-person diagnostic interview on the cognitive insight level of psychotic patients with an insight at the denial level. Indian J Psychol Med. 2016;38:217–23.